CHAPTER 1

INTRODUCTION

PURPOSE

As Connecticut approaches the year 2000, it faces many challenges. Connecticut is witnessing a dramatic change in the organization, delivery, and financing of personal health care services, a result of the development and expansion of managed care. This change carries with it the promise of greater efficiency at a reduced cost, but it also introduces the possibility of threats to the quality of care people receive and access to the health services they need. The cost of delivering services continues to increase, and this escalation burdens private employers and government alike by consuming more and more of the available resources. The number of uninsured is increasing, and the public health system, which traditionally provides a safety net for individuals, is straining under the pressure of competition for insured patients and no competition for the uninsured.

If difficult decisions need to be made about health priorities and the allocation of scarce resources, they need to be made based on quality information and analysis. It is the goal of this *Assessment* to provide these to state and local policy makers, planners, and the citizens of Connecticut.

Connecticut's last comprehensive state health plan, *Health, Connecticut...Looking Ahead, Planning Ahead*[1], was published in 1986 to inform policy makers and the public about the health of Connecticut residents, the state's health care delivery system, the need for health services and programs, and their fiscal implications. The current document shares those objectives.

Chapters 1 and 2 *of Looking Toward 2000 - An Assessment of Health Status and Health Services* describe the infrastructure that protects the health and safety of the population and address the emerging issues facing public health. Chapters 3 and 4 provide an assessment of Connecticut's health status and components of the existing health service delivery system. Finally, Chapter 5 identifies the public health priorities for Connecticut in the next biennium.

[1] Connecticut Statewide Health Coordinating Council. *Health, Connecticut...Looking Ahead, Planning Ahead, 1986-1990 State Health Plan,* Hartford: State of Connecticut, Department of Health Services, 1986: 236 pp.

AUTHORITY FOR THE STATE HEALTH PLAN [2]

In 1987, the Department of Public Health (DPH) was mandated by the legislature to be the lead agency for public health planning and to assist in the development of collaborative planning activities that respond to public health needs.[3] In 1993, a mandate was added for a multi-year state health plan to provide an assessment of the health of Connecticut's population and the availability of health facilities in the state.[4] According to the statute, the plan is to include policy recommendations regarding the allocation of resources and the determination of public health priorities.

By statute, the state health plan also serves as a benchmark in certificate-of-need (CON) decisions. CON ensures that the state's health care resources are allocated appropriately by requiring health care facilities to obtain a determination of public need before making major capital expenditures or adding or decreasing beds or services. CON decisions are required to refer to the relationship of a facility's request to the state health plan.[5] Toward this end, the Connecticut legislature designated the Office of Health Care Access (OHCA) to establish a statewide health facilities plan as part of the state health plan:[6] For this assessment, DPH operated under a Memorandum of Agreement with OHCA to complete the utilization study, presented in Chapter 4.

WHAT IS PUBLIC HEALTH?

Public health is an organized set of activities that protects and promotes the people's health. In 1920 public health was defined as "the science and art of preventing disease, prolonging life, and promoting physical and mental health and well-being through organized community effort for the sanitation of the environment, the control of communicable infections, the organization of medical and nursing services, the education of the individual in personal health, and the development of the social machinery to assure everyone a standard of living adequate for the maintenance or improvement of health."[7] Nearly 70 years later, the Institute of Medicine published *The Future of Public Health*[8] and defined the mission of public health to fulfill society's interest in assuring conditions in which people can be healthy.

Public health responds to the changing health care environment with the consistent goal to reduce premature deaths and the incidence of disease and disability in the population. The overall goal of disease prevention is shared among the public and private sectors, communities, and individuals. Disease prevention occurs on three levels: primary, secondary, and tertiary. Primary prevention reduces disease and injury incidence before they occur, through health promotion and protection measures. An example of primary prevention is an immunization program for healthy children. Secondary prevention identifies the risk factors associated with a disease or injury and attempts to "correct departures from good health as early as possible."[9] This level of prevention reduces the prevalence of disease and disability. Cancer screening is an example of a secondary prevention measure. Tertiary prevention measures focus on alleviating some of the

---

[2] The complete text of statutes governing health planning activities in Connecticut is presented in Appendix A.

[3] Connecticut General Statutes, Department of Public Health, Chapter 368a, Section 19a-7, 1975-95.

[4] 1993 Connecticut Public Act 93-381.

[5] Connecticut General Statutes, Office of Health Care Access, Chapter 368z, Section 19a-637(a), 1973-1997.

[6] Connecticut General Statutes, Office of Health Care Access, Chapter 368z, Section 19a-634(b), 1973-1997.

[7] Winslow, C.-E.A.: The untilled fields of public health. Science 51 (January9):23-33, 1920.

[8] Institute of Medicine. *The Future of Public Health*. Washington: National Academy Press, 1988: 225 pp.

[9] Last, JM. Scope and Methods of Prevention. In: Last, JM, Wallace, RB, editors. *Maxcy-Rosenau-Last Public Health & Preventive Medicine*. East Norwalk: Appleton & Lange, 1992: 4.

effects on the population already symptomatic of disease and injury. An example of such measures is antibiotic treatment of wounds to prevent infection.

The substance of public health is organized through an infrastructure designed to prevent disease and injury, and promote health. To support this infrastructure, the Institute of Medicine defined three core functions of public health: assessment, policy development, and assurance. Assessment is the surveillance process that identifies public health threats and trends. Policy development is the decision-making process of selecting the most appropriate response to public health threats and trends. Assurance is pledging that the necessary services, including personal health services, for the protection of public health in the community are available and accessible to all persons. This assurance function is necessary to make sure that the community receives proper consideration in the allocation of federal and state as well as local resources for public health; and that the community is informed about how to obtain public health services.

Public health services include both population-based and personal services. Personal or direct health services involve a one-on-one interaction between a health care professional and a patient. Direct services address physical, mental, or social functioning of the individual and may be performed by health care professionals for the purpose of promoting, maintaining, and restoring health. These services include what most consider ordinary medical care, including inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-rays, and dental care. In contrast, the provision of population-based services is directly related to the provision of essential public health services. Population-based services are identified as interventions to alter the social and physical environment, to change health-related behaviors, or to reduce directly the risk of causing a health problem. These services are generally developed and available for an entire population of a community or the state rather than just for individuals. The State of Washington's health plan noted that "public health services are less visible and more difficult to understand than medical services. Overall, public health serves the community through education, sanitation, and regulation."[10]

Public health responsibilities and essential services were summarized in 1994 by the Essential Public Health Services Work Group convened by the U.S. Public Health Service, and endorsed by the American Public Health Association. The Work Group proclaimed the vision for public health is to see healthy people in healthy communities by means of promoting health and preventing disease. The document *Public Health in America*[11] identifies public health with the following responsibilities:

- Prevent epidemics and the spread of diseases;
- Protect against environmental hazards;
- Prevent injuries;
- Promote and encourage healthy behaviors;
- Respond to disasters and assist communities in recovery; and
- Assure the quality and accessibility of health services.

[10] Washington State Department of Health. *Public Health Improvement Plan*. Olympia: State of Washington Department of Health, 1994: 12.

[11] Essential Public Health Services Work Group of the Core Public Health Functions Steering Committee. Public health in America. Washington, D.C.: American Public Health Association, 1994.

Essential public health services are also recognized to include the following:

- Monitor health status to identify community problems;
- Diagnose and investigate health problems and health hazards in the community;
- Inform, educate, and empower people about health issues;
- Mobilize community partnerships and action to identify and solve health problems;
- Develop policies and plans that support individual and community health efforts;
- Enforce laws and regulations that protect health and ensure safety;
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable;
- Assure a competent public health and personal health care workforce;
- Evaluate effectiveness, accessibility, and quality of personal population-based health services; and
- Research for new insights and innovative solutions to health problems.

In order to meet these responsibilities and provide these services, public health requires a systematic approach to anticipate, control, and prevent disease and injury as well as diagnose and treat occurrences.

CONNECTICUT'S PUBLIC HEALTH INFRASTRUCTURE

Public health infrastructure refers to the federal, state, and local governments' capacity to meet the basic responsibilities of preserving the health of the community. This represents "a basic governmental responsibility to represent and lead the community in assessing health status and needs, to develop public policies and priorities, to preserve health, and to assure that the community is responding appropriately."[12] The public health infrastructure comprises federal, state, and local governments that provide surveillance, vital statistics, health information and education, epidemiological investigation, laboratory analysis, and administration.

Connecticut's public health infrastructure relies on federal, state, and local support of the same overall goals to improve health status and assure the availability of appropriate health care to all residents. At the federal level, the public health infrastructure sets direction and policy while supporting implementation at the state and local levels. Table 1-1 presents examples of federal government agency support and direction for the public health infrastructure in Connecticut for various disease prevention programs.

DPH is the administrative agency leading the public health initiatives in the state. For example, DPH serves as the Title V agency, federally designated office for primary care, state federally designated office of rural health, federal agency for facility certification for Medicare, and the lead agency in HIV/AIDS initiatives. The responsibilities of other state agencies have indirect and direct effects on the health of our residents and are key participants in the public health infrastructure. Many state agencies administer health services, and seven agencies, other than DPH, provide direct health care services or contract for such services for their clients. For example, the Department of Correction contracts for medical, dental, and psychiatric services to incarcerated individuals.[13] Clinical services are also provided, either directly or through contractual agreements, to clients under the jurisdictions of the Departments of Children and Families, Education, Mental Health and Addiction Services, Mental Retardation, Social Services, and Veterans' Affairs.

Table 1 - 1
Federal Support for Public Health Infrastructure in Connecticut

Federal Agency	Selected Supported Programs

[12] American Public Health Association. *Healthy Communities 2000: Model Standards, Guidelines for Community Attainment of the Year 2000 National Health Objectives*, 3rd edition. Washington: American Public Health Association, 1991: 3.

[13] Regulations of Connecticut State Agencies, Department of Corrections, Section 18-81-10, 1979.

U.S. Dept. of Health & Human Services (DHHS), Centers for Disease Control & Prevention	Chronic disease prevention and control CT Coalition on breast and cervical cancer prevention Tobacco prevention and control
DHHS - Health Resources and Services Administration	State Office of Primary Health Care State Office of Rural Health Maternal and Child Health Block Grant Preventive Health Block Grant
DHHS - Health Care Finance Administration	Clinical laboratory improvements Medical facilities certification
DHHS - Agency for Toxic Substances and Disease Registry	Building state capacity for health assessment State capacity for educating health professionals
U.S. Dept. of Agriculture	Tuberculosis control
U.S. Environmental Protection Agency	Water supply supervision grant State lead program grants
U.S. Dept. of Housing and Urban Development	Lead-based paint abatement and hazard reduction
Social Security Administration	Vital statistics

Source: DPH, Office of Policy, Planning, and Evaluation

CONNECTICUT'S LOCAL HEALTH INFRASTRUCTURE

Local health departments (LHDs) are critical providers of population-based essential public health services at the local level in Connecticut. These departments are governmental entities separate from DPH, but are linked by statute in several important ways: approval of appointments of directors of health by the Commissioner of Public Health; mandates to carry out critical public health functions in the areas of infectious disease control in the community, environmental health, etc.; legal authority to levy fines and penalties for public health code violations, and to grant and rescind license permits (such as for food services establishments or septic systems); and funding to carry out the full area of public health activities to improve the health of people in their jurisdictions. Municipal health authorities and districts must include in their responsibilities the enforcement of the state public health code as required by DPH. Often this is a difficult task with the wide variety of services needed and the limited municipal budget to pay for those services.

Each municipality[14] in Connecticut is served by a local health department or district. Local health departments, whether part-time or full-time, serve under the direction the municipal legislative body (i.e. Board of Selectpersons or Town Council) of the community served. Municipalities having a population of 40,000 or more for five consecutive years are required to be served by a full-time director of health.[15] In 1997, there were 69 part-time and 26 municipal full-time health departments. There were also 18 health districts serving 83 municipalities. A health district is a regional health department formed by two or more municipalities to provide full-time public health services. The health district serves under the direction of a board of directors representing the member municipalities. A summary of local health departments are shown in Table 1-2. A complete list of health departments and districts by municipality is presented in Appendix B. Map 1-1 illustrates the communities served by a local health department and those served by a health district.

Table 1-2
Local Health Departments and Districts
Connecticut, 1997

	State	Municipal Health Department		Regional Health District
Description	Total	Part-time	Full-time	Full-time

[14] The Secretary of State's Office recognizes 169 municipalities and 8 boroughs in Connecticut. However, there are 178 distinct municipalities that are served by a local health department or district, comprising 170 cities and towns (including the city of Groton) and 8 boroughs.

[15] Connecticut General Statutes, Municipal Health Authorities, Chapter 368e, Section 19a-200(a), 1949-1995.

Number of departments	113	69	26	18
Number of municipalities	178	69	26	83
Estimated population	3,269,858	1,173,016	410,494	1,686,348
Percent of population served	100%	36%	12%	52%

Source: DPH, Local Health Administration, July 1, 1997; and DPH, OPPE, 1997 Population Estimates.

Local health departments are funded primarily with municipal appropriations, but they also receive state grants, federal grants, and private foundation moneys. In addition, they generate revenues from fees and licenses and the imposition of fines and penalties. State "per capita" funding is available to local health departments as long as program components found in "Basic Local Health Program"[16] are provided to the community. The 8 essential public health services provided through the local health infrastructure are health planning, communicable and chronic disease control, health education, environmental health services, community nursing services, nutrition services, maternal and child health services, and emergency medical services. In addition, municipalities must commit a minimum of $1.00 per capita from the annual tax receipts for a health department to receive state "per capita" funds.

Local health departments are fiscally encouraged to form regional health districts. In 1997, a municipality with a full-time director of health can receive annual funding equal to $0.52 per capita. Health districts are supported with greater annual incentives of $1.78 per capita for member towns with a population less than 5,000 and $1.52 per capita for member towns with a population greater than 5,000.[17] DPH budgeted over $2.5 million for essential local public health services in FY 1998.[18]

Other participants in Connecticut's local public health infrastructure are the service providers, often contracted by local health departments to operate outpatient clinics. A complete inventory of Connecticut's public health "safety-net" providers is found in Appendix G. The workforce that directly serves the public (i.e., physicians, nurses, technicians) and the facilities where the services are provided also support the local health infrastructure. The workforce environment and analyses of service utilization in a variety of health care settings are discussed in Chapter 4.

16 Regulations for Connecticut State Agencies, Connecticut Department of Health Services, Section 19a-76-4, 1983.

17 Connecticut General Statutes, Municipal Health Authorities, Chapter 368e, Section 19a-202 and District Departments of Health, Chapter 368f, Section 19a-245, 1949-1995.

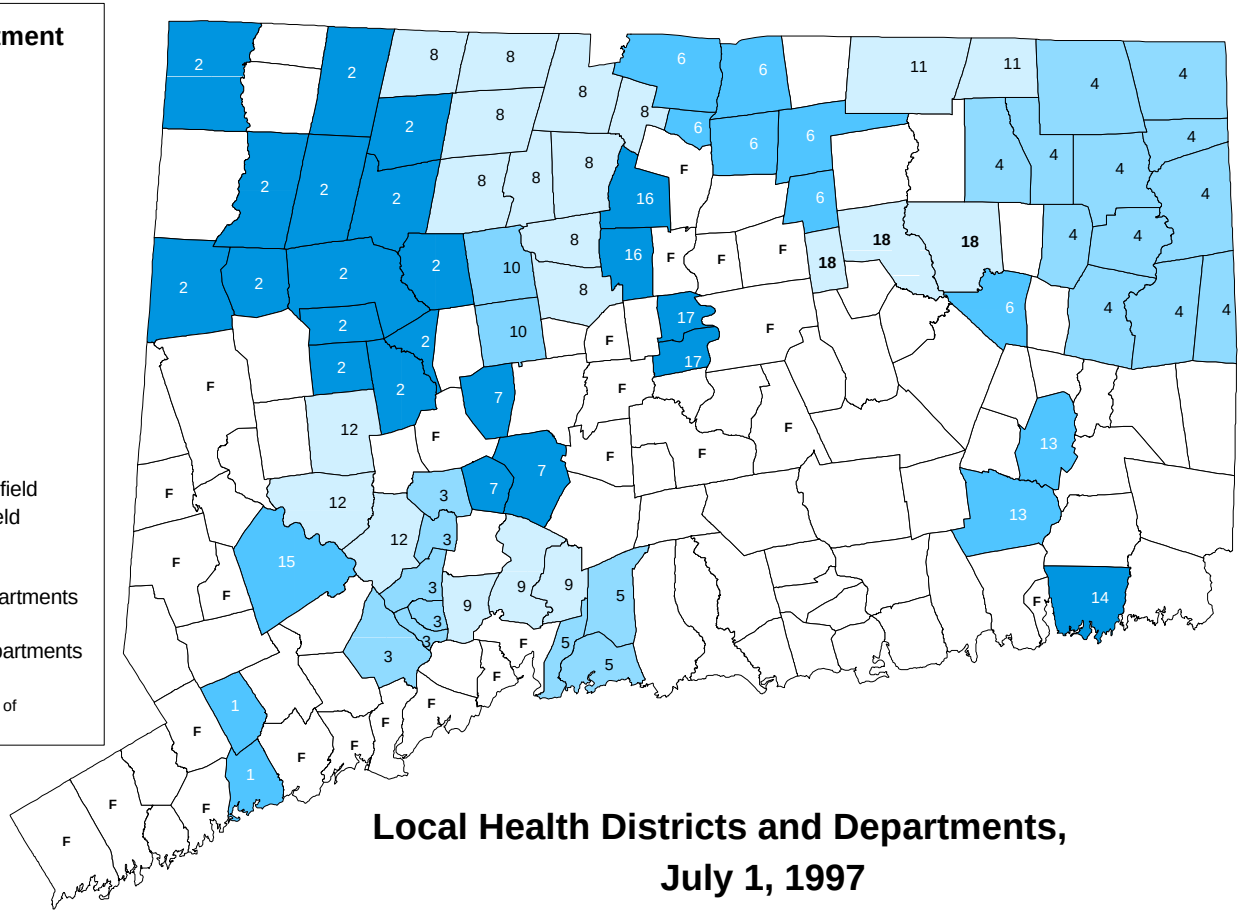
18 Public Act 98-250 amended C.G.S. 19a to increase state funding to $1.02 per capita for full-time municipal health departments. District health departments are eligible to receive $2.09 per capita for each town, city or borough with a population of 5,000 or less, and $1.79 per capita for municipalities with a population greater than 5,000. Part-time municipal health departments will receive $0.53 per capita. Restrictions and regulations for eligibility and use of funds remain the same.

Map 1-1

District* or Department

1 Weston-Westport
2 Torrington Area
3 Naugatuck Valley
4 Northeast
5 East Shore
6 North Central
7 Chesprocott
8 Farmington Valley
9 Quinnipiack Valley
10 Bristol-Burlington
11 Stafford
12 Pomperaug
13 Uncas Regional
14 Ledge Light
15 Newtown
16 West Hartford-Bloomfield
17 Rocky Hill-Wethersfield
18 Eastern Highlands
F Individual Towns with Full-time Health Departments
☐ Individual Towns with Part-time Health Departments

* Numbers are assigned in order of date of formation of health district



Local Health Districts and Departments, July 1, 1997

Source: DPH, Local Health Administration

PUBLIC HEALTH PLANNING

Connecticut utilizes population-based planning to assess health status, measure the availability of health services, and promote those services appropriate to the needs of state residents. Population-based planning concerns "the entire population of a designated region to specify the changes in existing resources needed to meet the health service requirements of that population."[19] The focus of population-based planning from its inception in the 1930's is the coordination of public health services to increase access to them.

The last DPH state health plan[20] addressed priorities in the areas of the evaluation of health status and Connecticut's health care delivery system. Health status priorities included: wellness and health promotion initiatives; continuation of traditional local public health services; reduction of infant mortality rates, low birthweight births, and teen births; and continued development of the State's capacity to protect its water supplies. Health care delivery priorities included: improved data capacity to monitor changes in the health care system; increased attention to planning for health services for the elderly; and the development of cost-effective, quality health care services. These priorities were reviewed in the 1989 DPH *Strategic Plan*[21] that served as a springboard for aggressive programs in high need areas. The consistent theme of the plan was a total commitment to address the unmet needs of Connecticut's most disenfranchised citizens.

In 1987 Connecticut lawmakers established the Connecticut Community-Based Health Planning Program[22], which focused on the assessment, policy development, and assurance of essential preventive and primary care services and on their relationship to public health issues and service needs. Major program goals were: 1) to develop community health planning capacities for assessing essential preventive and primary care services; and 2) to implement specific action strategies to improve the public's health. The program focused on activities to improve access to both primary care and preventive health services, but was ended in 1990 due to Connecticut's fiscal constraints.

Seven state agencies are involved with health planning to support the core functions of public health. They are DPH, OHCA, Department of Mental Health and Addiction Services (DMHAS), Department of Mental Retardation (DMR), Department of Children and Families (DCF), Department of Social Services (DSS), and the Office of Policy and Management (OPM). DMHAS prepared a "Substance Abuse and Mental Health Needs Assessment" which is presented in Appendix C. Health planning coordination and collaboration among agencies are encouraged by the legislature and the agencies, themselves. For example, the development of a strategic planning unit in DSS, DMHAS, DMR, and DPH is supported by legislation to centralize policy development and promote interagency coordination of health and human services.[23]

---

[19] Rundall, TG. Health Planning and Evaluation. In: Last, JM, Wallace, RB, editors. *Maxcy-Rosenau-Last Public Health & Preventive Medicine*. East Norwalk: Appleton & Lange, 1992: 1080.

[20] Connecticut Statewide Health Coordinating Council.

[21] Connecticut Department of Health Services. Summaries of Strategic Plans 1989 - 1992. Hartford:, 1992.

[22] Connecticut General Statutes, Department of Public Health, Chapter 368a, Section 19a-7, 1975-95.

[23] Connecticut General Statutes, Department of Social Services, Chapter 319o, Section 17b-6(b)(5), 1992.

PLANNING FOR THE FUTURE

Healthy People 2000

The most notable planning efforts on the national, state, and local levels are "Year 2000" initiatives with specific goals and objectives designed to improve health status and the public health infrastructure in the next century. *Healthy People 2000*[24] is a national strategy for improving the health of the American people that reflects a new appreciation for the prevention of illness and disability. *Healthy People 2000* places greater emphasis on health outcomes than on premature mortality, and has as its goals to (1) increase the span of healthy life for Americans, (2) reduce health disparities among Americans, and (3) provide access to preventive services to all Americans.

These goals are supported by 300 objectives that address 22 priority areas in health promotion and protection, preventive services, and data surveillance. A U.S. Public Health Service agency was designated to develop an implementation plan and to coordinate activities to achieve the objectives in each priority area. Appendix D contains a complete listing of priority areas and designated agencies. The Centers for Disease Control and Prevention (CDC) is responsible for health surveillance and for developing supporting data systems. As a result, CDC developed a set of 18 health status indicators (consensus indicators), to facilitate national, state, and local tracking of *Healthy People 2000* objectives and to help communities assess the general health status of their population. (Appendix D).[25]

Healthy Connecticut 2000

Connecticut responded to the national initiative with the Healthy Connecticut project, which was a coordinated, internal review of *Healthy People 2000* and DPH's three-year strategic plan to ascertain which specific objectives were being addressed through programs and which were not. By the end of 1992, DPH determined that the state was making progress in reducing the incidence of cardiovascular disease, infant mortality, AIDS, and other infectious diseases. However, the areas of cancer, violence, unintentional injuries, and diabetes required more attention.

The Healthy Connecticut project resulted in the 1992 DPH publication of the *Healthy Connecticut 2000 Baseline Assessment Report.*[26] The purposes of the effort are to: 1) describe our health status; 2) establish objectives; 3) provide a framework for policy development; 4) assist DPH in setting program priorities; 5) serve as a basis for health planning; and 6) enable Connecticut to remain competitive in obtaining federal funds for public health.

The *Healthy Connecticut 2000 Baseline Assessment Report* provides a framework for program planning, evaluation, policy development, and assurance. The report originally contained 112 objectives that focus on health status (to reduce death, disease, and disability) and risk reduction (to reduce the prevalence of risks to health). The objectives are divided into 18 priority areas that are listed with the national priorities in Appendix D. DPH recently completed a third set of objectives[27] known as services and protection objectives, which serve to increase comprehensiveness, accessibility, and/or quality of preventive services and interventions. These objectives serve to implement the health status and risk reduction objectives published in 1992.

---

[24] U.S. Department of Health and Human Services. *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. Washington: U.S. Public Health Service, 1990: 692 pp.

[25] The U.S. Department of Health and Human Services has begun development of *Healthy People 2010 Draft Objectives* for review and comment. A final publication is due during the year 2000.

[26] Connecticut Department of Public Health. *Healthy Connecticut 2000 Baseline Assessment Report.*, 1992: 250 pp.

[27] Connecticut Department of Public Health. *Healthy Connecticut 2000 Baseline Assessment Report Replacements and Additions*, July 1997.

Performance Measurements

Performance measurements are being developed at the national and state levels as a management tool for documenting goals and objectives and the results from the investment in public health. Performance measurements respond to the increasing need to ensure the efficient and effective use of resources. At the federal level, performance measurements will support the Government Performance and Results Act of 1993[28] (GPRA) which requires the establishment of performance measures for programs. Under GPRA, federal agencies must submit an annual performance plan, beginning with the President's 1999 budget, that includes defined targets for performance goals, outcome indicators to measure progress toward the goals, a description of resources needed to meet the goals, a basis for computing actual program results with the goals, a discussion of the process for validating the data that are collected, and an acknowledgment of the role of other parties in meeting goals.

However, the performance measurement process for selected public health programs is intended to build on and strengthen the activities in *Healthy People 2000* and the Healthy Communities 2000 initiatives. The process is intended to develop performance measurements for public health programs in chronic disease, disability prevention, emergency medical services, HIV, sexually transmitted diseases, tuberculosis, immunizations, mental health, rape prevention, and substance abuse.

Connecticut Benchmarks for the Year 2000

In support of the Year 2000 efforts, the Connecticut Progress Council published in 1995, the *State of Connecticut Goals and Benchmarks for the Year 2000 and Beyond* to establish broader community goals and objectives designed to measure Connecticut's progress in forming its future. Forty-one goals and 300 benchmarks were organized into five sections: individuals, families, and communities; education; health; the economy; and the environment. There were clear connections among goals and benchmarks of the different sections. The health goals emphasize the need for healthy lifestyles, reduced levels of violence, prevention, and equitable access to health care. Many of the 74 health benchmarks correspond with *Healthy Connecticut 2000* objectives. The Progress Council's health goals are:

1. All Connecticut residents will enjoy complete physical, mental and social well-being.
2. All Connecticut residents will be safe from injury and violence in their homes and communities.
3. All Connecticut residents will enjoy an environment that minimizes their exposure to unhealthy levels of toxic substances from food, air, and water in community and occupational settings.
4. All Connecticut residents will experience the rewards of pursuing exercise, nutrition, freedom from substance abuse and other aspects of positive health habits and lifestyles.
5. Illness and injury will be minimized by regular prevention-oriented research, education and health care.
6. All Connecticut residents will enjoy equitable access to the benefits of quality public health services and medical care.

[28] Public Law 103-61. The Government Performance and Results Act of 1993. 8/2/93.

Healthy Communities

Over the past decade, there has been increasing support at the national, state and local levels for healthy community initiatives. These initiatives focus on the need for community level interventions to improve the overall health and quality of life for communities by organizing the business, government, and health sectors to address local issues and needs. Policy-makers, providers, and consumers in health care have come to view health as an outcome, directly related to factors such as education, lifestyle, income, nutrition, and sanitation. The healthy community concept relies on personal and community responsibility for determining health status.The community often begins by developing a local needs assessment process. The assessment includes a traditional review of health status and available resources along with a look at related issues such as rising crime, depressed economies, and quality of health and education programs. The results contribute the information necessary for the stakeholders to develop policy and strategies that are tailored to the community's needs and resources. The policy consensus of a stakeholders' group promotes the unity of the community and allows the participants to work together to remove the obstacles to optimum health status. In addition, a collaborative intervention such as violence prevention programs through schools, police, and local health departments can be more cost-effective than each agency supporting independent programs.

In support of the healthy communities initiatives, the Joint Commission on Accreditation of Health Care Organizations (JCAHO) has updated their quality of care standards to include service planning in response to community needs.[29] This action has brought the hospitals into a more active role in community health planning. Many healthy communities initiatives exist in Connecticut. Some of the efforts were initiated by local hospitals in response to accreditation requirements, and others arose from local health departments in response to *Healthy People 2000*. It appears that, regardless of the impetus, the communities are willing to take responsibility for assessing overall health status and combining efforts to address the needs identified. Collaboration in both assessment and policy development brings a two-fold benefit to the community - a documentation of need and a council of representatives already in place to address future changes and needs in the community. A summary of selected healthy community initiatives in Connecticut is presented in Appendix E.

[29] Joint Commission on Accreditation of Healthcare Organizations. *Comprehensive Accreditation Manual for Hospitals The Official Handbook*. Washington, D.C. : 1996: LD8-LD12.